GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR REHABILITATION CLOSURE

Submitted by: ❑ Claimant ❑ Employer / Insurer ❑ Supplier

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

SECTION 1 IDENTIFYING INFORMATION

EMPLOYEE	Occupation	Catastrophic Injury? ❑ Yes ❑ No	County of Injury	Birthdate

Fill out information in Section 2 and check appropriate status in Section 3 for return to work cases. If not returned to work, check appropriate status in Section 4. Record costs in Section 5.

SECTION 2 RETURN TO WORK INFORMATION

Employer's Business Name				Address		
Supervisor's Name		Phone Number				
Job Title		Employment Date				
Previous Weekly Wage	Previous Hours per Week	Present Weekly Wage	Present Hours per Week	City	State	Zip Code

SECTION 3 RETURN TO WORK STATUS

- ❑ Closed After Evaluation/Working
- ❑ Same Employer, Same or Modified Job
- ❑ Same Employer, Different Job
- ❑ Same Employer, OJT
- ❑ New Employer, Different Job
- ❑ New Employer, OJT
- ❑ New Employer, After Training
- ❑ Self-Employment
- ❑ RTW After Settlement
- ❑ Other (Specify):

SECTION 4 NOT RETURNED TO WORK

- ❑ Rehabilitation Not Needed
- ❑ Rehabilitation Not Feasible
- ❑ Medical Goal Attained
- ❑ Settled, Rehabilitation Closed
- ❑ Settled, Rehabilitation Expired
- ❑ Change of Supplier
- ❑ Closed for Training
- ❑ Board Decision (Attach Copy)
- ❑ Other (Specify):

SECTION 5 REHABILITATION COST

(This section must be completed by rehabilitation supplier)

1. Number of Weeks	2. Medical Care Coordination	3. Vocational Services	4. Total Rehabilitation Costs

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

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SECTION 6 CERTIFICATE OF SERVICE

❑ I certify that I have mailed copies to the following parties on _____ (Month) / _____ (Day) / _____ (Year) at the current addresses below.

Print or Type Name	Signature

EMPLOYEE	Last Name	First Name	M.I.	Address		
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYER	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
INSURER / SELF-INSURER	Name			Address		
CLAIMS OFFICE	Name					
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYEE'S ATTORNEY	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
EMPLOYER'S ATTORNEY	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
SITF	Name			Address		
E-mail Address		Telephone Number		City	State	Zip Code
REHABILITATION SUPPLIER	Name	Registration No.		Address		
E-mail Address		Telephone Number		City	State	Zip Code

Do all parties agree to this closure? ❑ Yes ❑ No

SECTION 7 APPROVAL / OBJECTIONS, TWENTY (20) DAY NOTICE

Absent written objections within 20 days of the date mailed, the rehabilitation request is approved effective the date of the certificate of service. No further correspondence will be issued by the Board. If there is an objection:

(1) The Objection must be in writing.
(2) It must be received by the Georgia State Board of Workers' compensation within 20 days of the date of the Certificate of Service.
(3) A Certificate of Service must be completed stating that copies of the written objections were placed in the mail to all parties and the principal rehabilitation supplier the same date as the Certificate of Service.

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